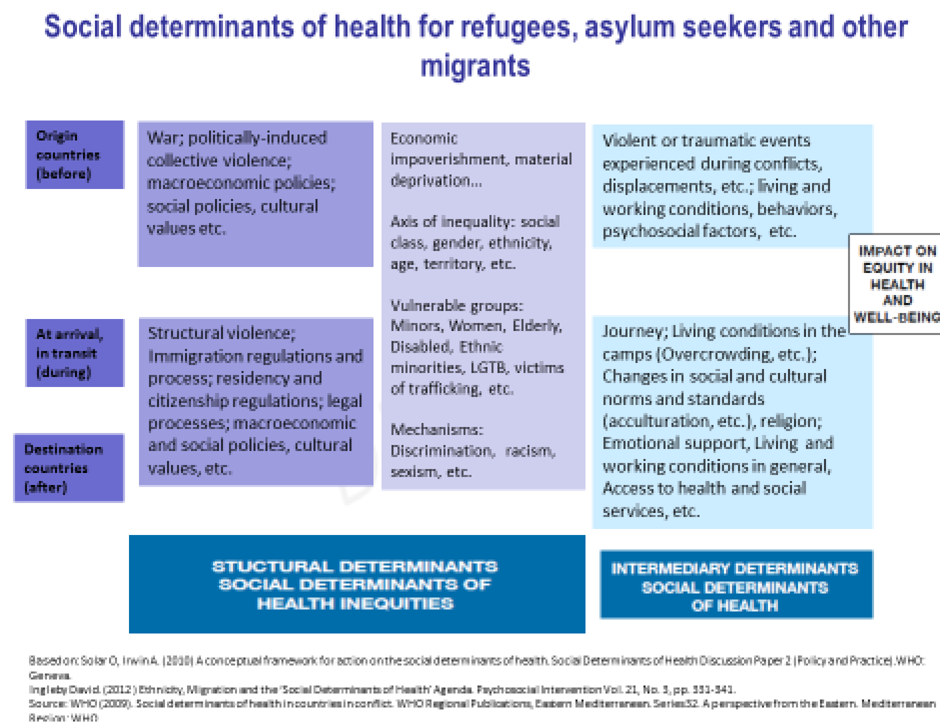
Presentation

Social determinants for refugees, asylum seekers and other migrants



Migration in Europe today involves a diverse group of people, including migrants in a regular and irregular situation, victims of human trafficking, asylum seekers, refugees, displaced persons and returnees. Considering refugees, asylum seekers and other migrants, unambiguous distinctions between country categories are impossible to draw, however it is important to address different scenarios. The different phases of a migration trajectory underlie various health needs, problems, and available health protection resources[1]. The origin of health problems may lie in the destination countries, during the journey/at arrival, or in the countries of origin[2].

In host/destination countries

According to the framework of CSDH, "Context" is broadly defined to include all social and political mechanisms that generate, configure and maintain social hierarchies, including the labour market; the educational system, political institutions and other cultural and societal values. Among the contextual factors that most powerfully affect health are the welfare state and its redistributive policies (or the absence of such policies)[3]. Immigration regulations, residency and citizenship regulations are one of the main structural determinants of refugees and other migrant's health.

[1] Access to health in terms of entitlements to health care services are determined by the status of the migrant as arriving or "in transit", waiting to apply for asylum, asylum seeking or granted protected status.

[2] Gushulak B, Pace P, Weekers J (2010). Migration and health of migrants. In: *Poverty and social exclusion in the WHO European Region: health systems respond.* Copenhagen, WHO Regional Office for Europe.

[3] Solar O, Irwin A. (2010) A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice).WHO: Geneva.

Social, economic and political mechanisms give rise to a set of socioeconomic positions, whereby populations are stratified according to income, education, occupation, gender, race/ethnicity and other factors; these socioeconomic positions in turn shape specific determinants of health status (intermediary determinants) reflective of people's place within social hierarchies; based on their respective social status, individuals experience differences in exposure and vulnerability to health-compromising conditions.

Important intermediate determinants are unemployment or precarious employment, and precarious living conditions in general. Once in the country of destination, refugees' and migrants health can be affected by a serious decline in their standards of living (housing conditions, unemployment or underemployment, social isolation and low income). Many migrants work in so-called "3D jobs" – "dirty, demanding and dangerous"[4]. Post-displacement social factors such as employment, financial status, and satisfaction with accommodation were important determinants of refugee mental health in new refugees in UK[5]. According to a recent overview of the topic[6], migrant workers experience higher rates of industrial accidents, injuries and work-related diseases. Because of their precarious employment conditions and poorer access to health services, many work-related illnesses may go unreported and treated.[7]

According to WHO Europe "*access to employment is a major aspect of social and economic inclusion. Levels of poverty are noted to be higher in the unemployed and other inactive members of society (…) Rates of unemployment vary by country, but there is evidence to indicate that employment income is reduced in migrant populations, particularly those of irregular migrants (…) Working people whose income is less than 60% of the median national income are at greater risk of poverty-associated outcomes (…) Some migrant populations are at particular risk of poverty (…) migrants in an irregular situation; asylum seekers; single-parent migrant families, specifically those headed by women; those traumatized or tortured during the migratory process; and the victims of human trafficking*"[8].

Socio economic status (SES) is part of the causal chain between migration status and health, if membership of these groups to some extent determines a person's SES. WHO Europe report on poverty and social exclusion lists a number of health risks correlated with refugees and other migrants social conditions:

- poverty related to social exclusion;
- lack of appropriate housing/accommodation;
- poor diet;
- low level of income associated to low education level, employments not commensurate with their education, precarious employment or unemployment .

4 McCauley, L.A. (2005) Immigrant workers in the United States: recent trends, vulnerable populations, and challenges for occupational health. Journal of the American Association of Occupational Health Nurses, 53(7), 313–19.
5 Campbell Mark. Social determinants of mental health in new refugees in the UK: cross-sectional and longitudinal analyses, Meeting Abstracts, November 2012, p27.
6 Agudelo-Suárez, A.A., Ronda-Pérez, E. & Benavides, F.G. (2011). Occupational health. In: Rechel et al., op cit., 155-168.
7 De Jong, et al (2014). Current and emerging issues in the healthcare sector, including home and community care. European Agency for Safety and Health at Work. Available at: https://osha.europa.eu/en/publications/reports/current-and-emerging-occupational-safety-and-health-osh-issues-in-the-healthcare-sector-including-home-and-community-care (retrieved: February 18, 2015).
8 Gushulak B, Pace P, Weekers J (2010). Migration and health of migrants. In: Poverty and social exclusion in the WHO European Region: health systems respond. Copenhagen, WHO Regional Office for Europe

Some of these factors are shared with other groups affected by poverty and some are specifically associated with the migratory process[9].

In addition, there may be a *direct* relationship between discrimination and poor health.[10] Other factors in the settlement phase such as insecurity of the asylum application, fear for the safety of family members, legal and bureaucratic difficulties in family reunification, adaptation to the new environment (e.g. new language, habits and culture) and hostile attitudes within the country of asylum might have an impact on refugee health, especially mental health. ECCRE[11] has reported the negative impact on health of the long waiting period for the processing of an asylum application (smoking, drinking, drug abuse and suicide attempts are also known to increase during such a period); a long stay in a reception centre and / or in bad housing conditions; prolonged inactivity.

Many refugees experience difficulties in expressing health needs and in accessing health care. Many important problems experienced in providing health care for migrants have to do with the complex administrative arrangements for accessing care and a variety of challenges to providing quality care by professionals. Some barriers identified include inadequate information, particularly for new migrants unfamiliar with health care systems, insufficient support in interpreting and translating for people, lack of access to reliable transport because of poverty and poor services in areas of deprivation where many recent migrants live, confusion around entitlement to some types of services particularly among migrants with insecure immigration status as well as among service providers and cultural insensitivity of some front line health care providers[12] In any case, measures to reduce health inequalities may need to be specially adapted in order to reach refugees and other migrant groups effectively. In host countries, the basic health needs of refugees, asylum seekers or other migrants are broadly similar to those of the host population, although previous poor access to health care may mean that many conditions have been untreated: They can suffer from communicable diseases, such as tuberculosis or hepatitis, as well as respiratory diseases associated with poor nutrition, the cold, overcrowding, and inadequate sanitation, water supply and housing, compounded by limited access to health care. Coming from different countries and cultures, they have had, in their own and other countries, a wide range of experiences that may affect their physical and mental health. Refugees can suffer from a range of health problems relating to their experience of political persecution, imprisonment, torture and the conditions of the journey from their country of origin.

During the journey, and first arrival

9 Gushulak B, Pace P, Weekers J (2010). Migration and health of migrants. In: Poverty and social exclusion in the WHO European Region: health systems respond. Copenhagen, WHO Regional Office for Europe

10 Pascoe EA, Smart Richman L (2009). Perceived discrimination and health: a meta-analytic review. Psychological Bulletin, 135:4:531–554.

11 ECCRE Good practice guide on the integration of refugees in the European Union: Health http://www.ecre.org/component/downloads/downloads/187.html

12 Jayaweera H. (2014). Health of Migrants in the UK: What Do We Know? The Migration Observatory at the University of Oxford. http://www.migrationobservatory.ox.ac.uk/sites/files/migobs/Briefing%20-%20Health%20of%20Migrants%20in%20the%20UK_0.pdf

As reported by Medecins Sans Frontières (MSF) [13] undocumented migrants and asylum seekers set off to South Europe on boats leaving the coast of Syria, Libya, Algeria and Morocco on journeys that can take up to seven days. In detention centers they face overcrowding, inadequate sanitation, and poor general living conditions, an environment that has damaging effects on their physical and mental health. About 17% of the health conditions diagnosed by MSF medical staff were respiratory problems linked to exposure to cold and lack of treatment for infections. Skin infections reflected overcrowding and poor hygiene in the centers.

Each year, thousands of migrants arrive to European coasts after harsh boat journeys across the Mediterranean Sea to Europe. Those who survive the journey arrive exhausted and dehydrated, suffering from respiratory infections and skin complaints caused by overexposure to salt and water, as well as burns from fuel accidents and injuries. The majority of people arriving to Greece and Italy originate from Syria, Afghanistan, Iraq, Palestinian Territories, and Somalia. For these arrivals, Southern European countries are usually a transit location on the way to Northern Europe.

Morocco is a place of transit and enforced stay for migrants from sub-Saharan Africa. The presence of migrants in some rural areas of the border with Algeria and Spanish cities of Ceuta and Melilla has led to regular raids by Moroccan security forces. MSF has reported violence suffered by migrants and asylum seekers from both the security forces and other actors e.g. human-trafficking networks. Because migrants are forcibly detained in Morocco, risky behaviours have started to appear, linked to activities that generate economic income. These activities include sexual exploitation, prostitution, and forced labour linked to human-trafficking networks. Consequently, migrants face new health problems linked to sexual and reproductive health.

Origin countries

When in the country of origin there is a situation of conflict, it is important to consider how conflict affects social determinants and health results in country origins.

Life Course perspective. Different exposures

The 'life-course' perspective considers that there may be highly complex interactions between all three factors. The diagram (adapted from Reeske & Spallek, 2012[14]) illustrates the complexity of these determinants of migrant' health. It must also be borne in mind that these factors do not affect health directly, but though various intervening variables and pathways. Many different kinds of factors may underlie the prevalence of disease among migrant groups.

Illustrates the complexity of these determinants of migrant' health. It must also be borne in mind that these factors do not affect health directly, but though various intervening variables and pathways. Many different kinds of factors may underlie the prevalence of disease among migrant groups:

[13] Medecins sans Frontières, Migrants, refugees and asylum seekers: Vulnerable people at Europe's doorstep http://www.doctorswithoutborders.org/sites/usa/files/MSF-Migrants-Refugees-AsslymSeekers.pdf (retrieved: November 25, 2014)

[14] Reeske, A. and Spallek, J. (2012) Obesity among migrant children and adolescents: a life-course perspective on obesity development. In: Ingleby, D., Krasnik, A., Lorant, V. & Razum, O. (Eds.) *Health inequalities and risk factors among migrants and ethnic minorities. COST Series on Health and Diversity, Volume I* (pp. 237-256). Antwerp/Apeldoorn: Garant

Genetic factors
Particular genetic differences may well be the key to understanding differences between population groups in their vulnerability to certain diseases. It has long been known that sickle-cell anaemia occurs predominately in African Americans, while Tay-Sachs disease is mainly found in Ashkenazi Jews. Developments in genetic profiling will undoubtedly discover more such links, though intermarriage and complex interactions with other factors weaken the impact of any such effects.

Cultural factors
Differences in lifestyle linked to 'culture' have been a popular type of explanation in the study of migrants' health.

However, there are two main problems with explanations in terms of 'culture'. Firstly, the notion that each ethnic group or country of origin is associated with a stable and homogeneous culture has come under fire in recent decades. Secondly, lifestyles are not practised in a vacuum: healthy eating, for example, is not just a personal choice but also depends on the availability and affordability of the right foodstuffs, as well as having the time and facilities to prepare them. Advertising and social pressures are also powerful determinants of behaviour.

Health system factors
Health may be impaired by shortcomings of the health system in providing adequate prevention programmes, health education and promotion, or health services that are accessible and of high quality. However, a shift has occurred in *interventions* aimed at improving the health of these groups. The focus has moved influenced by the "social determinants of health" movement associated with the "Marmot Report"[15].

Lifestyle factors
The importance of *prevention* has been widely emphasised since the WHO's 1978 'Declaration of Alma Ata' and even before. Some preventive measures are targeted at individuals and aim to induce *behavioural change.* This can either have the aim of harm reduction or illness prevention. Recently there has been a great increase in attention to behavioural ('lifestyle') factors as determinants of both communicable and non-communicable illnesses[16].

Social determinants of health in conflict settings

Conflict is a major social determinant of health in several regions and countries, generating a state of humanitarian crisis as a result of armed conflict and/or occupation. The social determinants of health in conflict settings reflect and further

[15] CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on the Social Determinants of Health. Geneva, World Health Organization

[16] WHO (1978). Declaration of Alma-Ata. Geneva, World Health Organization.

reinforce these inequalities and the vulnerability of those who are disadvantaged because of poverty, marginalization and discrimination [17]

Structural determinants include:

- the loss of human rights which are usually addressed during emergency responses but which also need to be addressed in the long term through building up capacities;
- breaches of medical neutrality which require national and international action and the involvement of nongovernmental organizations.

Intermediate determinants include:

- stress, distress and disease: tackling mental health problems in the social setting rather than through individual counselling.

Thematic areas as guides to action include:

- vulnerable groups: everyone is vulnerable;
- loss of livelihood;
- loss of community support and social networks;
- provision of, and access to, health services.

Source: WHO (2009). Social determinants of health in countries in conflict. WHO Regional Publications, Eastern Mediterranean. Series 32. A perspective from the Eastern. Mediterranean Region: WHO

According to this report, conflicts develop within the context of longstanding inequalities and social conflicts, exacerbated by the breakdown of civil authority, and are associated with:

• competition for power and resources, such as land and livelihoods, food security (the ability to import food as well as to access local supplies), water and oil;
• cross-cutting local identities that reflect social, political, economic, religious, ethnic and cultural structures and divisions;
• predatory social domination, which occurs in especially vicious forms with the breakdown of civil authority.

The impact of conflict on morbidity and mortality can be direct or associated. Morbidity and mortality directly due to conflict are death, injuries or disabilities caused by violence; associated with conflict are the poor health outcomes due to the combined impact of conflict, poverty and ineffective health systems.

Diseases results from constant, unremitting exposure to life-threatening situations, forced population movement; deliberate destruction of farmland and homes; barriers denying access to jobs; malnutrition; lack of social capital; loss of livelihoods and meaningful activities; lack of access to health care, etc. The social determinants of health in conflict settings reflect and further reinforce existing inequalities and the vulnerability of those who are disadvantaged because of poverty, marginalization and discrimination. [18]

[17] WHO (2009). Social determinants of health in countries in conflict. WHO Regional Publications, Eastern Mediterranean. Series 32. A perspective from the Eastern. Mediterranean Region: WHO

[18] WHO (2009). Social determinants of health in countries in conflict. WHO Regional Publications, Eastern Mediterranean. Series 32. A perspective from the Eastern. Mediterranean Region: WHO

Health risks before, during and after

Taking into account that refugees, asylum seekers and other migrants are not a homogeneous population (different phases of migratory process, countries of origin, destination countries, journey/transit experiences, legal status, etc.), some of the health concerns are[19,20,21,22,23]:

- Frequent health problems related to experience of political persecution, imprisonment, torture and conditions of flight from their country of origin. Symptoms of psychological distress are common.
- Those moving from poor socioeconomic environment may suffer from communicable diseases (TB, hepatitis) and respiratory diseases associated with poor nutrition, cold, overcrowding, inadequate sanitation, water supply and housing, compounded by previous limited access to health care.
- During the journey, respiratory infections and skin complaints caused by overexposure to salt and water, burns from fuel accidents and skin infections from overcrowding and poor hygiene in the reception centers.
- During the journey or in transit, many suffer violence from both the security forces and other actors (e.g. human-trafficking networks), sexual exploitation, prostitution, and forced labor, especially women and children.
- Once in the country of destination, social determinants and health problems broadly similar to those of the host population. Health problems related to decline in standards of living, insecurity of the asylum application, legal situation or entitlements, legal and bureaucratic difficulties, and process of adaptation to the centers, inactivity and hostile attitudes, fear for the safety of family members…
- Mental health status:
    - Generalized sense of hopelessness, absence of employment opportunities and social dysfunction.
    - Symptoms of post-traumatic stress disorder, depression, psychosomatic complaints and anxiety.

[19] ECCRE Good practice guide on the integration of refugees in the European Union: Health

[20] Medecins sans Frontières, Migrants, refugees and asylum seekers: Vulnerable people at Europe's doorstep http://www.doctorswithoutborders.org/sites/usa/files/MSF-Migrants-Refugees-AsslymSeekers.pdf;

[21] UNHCR Strategy 2014-18; Fazel, M., Wheeler, J., Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. The Lancet, 365:9467:1309–1314 ;

[22] Lindert, J. et al. (2009). Depression and anxiety in labor migrants and refugees – a systematic review and meta-analysis. Social Science & Medicine, 69:2:246–257;

[23] Ingleby, D. (ed.) (2005) Forced migration and mental health: rethinking the care of refugees and displaced persons. New York: Springer

- The origin of these problems may lie not in the country of origin, but in experiences endured during the flight, the asylum application procedure, etc.

Policy measures tackling social determinants for refugees, asylum seekers and other migrants

Policies are a key factor to improve access to health care and quality of care for refugees, asylum seekers and other migrants. Some measures to take into account are[24]:

Socioeconomic and political context

- National and international agreements, improving the rights of "non-citizens".
- Migrant integration policies
- Improving national and international policies against individual and institutional discrimination, and against social exclusion.
- Improving policies of redistribution of power, resources,
- Developing national and international policies on education, employment, social protection, housing, environment and health services, asylum and irregular migration.
- Inclusive educational policies, attention to linguistic and cultural barriers, underachievement, drop-out and segregation.

Material circumstances (living and working conditions, etc.) and other intermediate determinants

- Reducing barriers to labor market participation: tackling unemployment; precarious employment; better matching of work to qualifications. Reducing occupational health hazards: better information, inspection, implementation of safety regulations.
- Better housing, reduction of environmental hazards, improved transport and other amenities.
- Increased availability of healthy food, better targeting of "healthy eating" campaigns.
- Empower migrant and ethnic minority communities, mobilizing their health assets and strengthening social networks; combating isolation, loneliness and vulnerability
- Measures to improve knowledge of health risks and the ability to implement it. Strengthening healthy cultural traditions and questioning unhealthy ones. Encouraging avoidance of known risk factors and unhealthy lifestyles.
- More appropriate and culturally responsive accessible health services, improved monitoring of health status and service use, more and better research.

[24] "Policy Measures tackling determinants of health for migrants". In Rechel, B. et al eds., (2011) Migration and health in the European Union. European observatory on health systems and policies. Open University Press.p 8

Health system as a social determinant of health

The health system as a social determinant of health plays an important role through the issue of **access, which incorporates differences in exposure and vulnerability[25]. A recent coping review** considering 72 studies where refugees and asylum seekers formed part or all of the population studied states that the access to appropriate health care across the WHO European Region is very varied and is overwhelmingly shaped by legal frameworks and the regulation of the migration process. Access to health care for refugees and asylum seekers is not only a problem of acute provision at initial reception. If people spend longer in a resettlement camp then care for chronic as well as acute health needs is required. Although some provision is specifically provided in detention or reception centers, refugees and asylum seekers across the WHO European Region are also accessing health care from the same clinics as the general population; consequently, adapting mainstream provision is crucial. Some policy measures are recommended [26]:

Practical support to facilitate access to services could be provided through:

- removal of any legal restrictions on access to health care for asylum seekers and refugees;
- extension of full health care coverage to all children regardless of their immigration status;
- extension of full health care coverage to all pregnant women regardless of their immigration status with assistance at delivery and parity; and
- coordinated action between agencies within and beyond the medical system, including integration of housing, employment and education.

Linguistic barriers to quality health care could be addressed through:

- adoption of an intersectoral approach to the provision and distribution of health
- information in a range of languages;
- provision of professional interpreters, free of cost to the patient and health
- professional;
- provision of clear labelling for prescriptions with specific consideration for the language of the patient; and
- documentation of language and literacy levels of patients.

Utilization of services, particularly primary care, could be improved, with:

- provision of technical support for registering and making appointments, including
- language support and patient advocacy services;
- provision of free transport to and from appointments;
- longer appointment times, thus allowing for interpretation and explanation;
- provision of flexible opening hours and appointment times;
- gender specific requests being met and respected;
- development and delivery of quality training for professionals, considering
- cultural sensitivity in health care delivery; and
- increased awareness among health professionals of mental health issues for refugees and asylum seekers, particularly minors.

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[26] Bradby H, Humphris R, Newall D, Phillimore J. Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. Copenhagen: WHO Regional Office for Europe; 2015 (Health Evidence Network synthesis report 44)

The evidence on health issues for refugees and asylum seekers could be strengthened by developing information and monitoring systems to promote:

- comparative work across subsections of migrant and non-migrant populations,
- considering using the concept of "recency of arrival" to cut across different migrant statuses at this entry stage;
- coordination of data across governmental and nongovernmental agencies;
- examination of the health effects of different phases of the asylum process;
- assessment of the long-term health impacts of initiatives relating to integration in housing, employment and education;
- understanding of the correlation between integration policy and good health
- outcomes in maternity and mental health;
- development of non-stigmatizing concepts for research and monitoring; and
- address of migrants' own priorities and where these may be at odds with those of professionals.

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